Requestor/Applicant/Participant Name (print):	
Last 4 digits of SSN:	**DOB:**

Responsible Representative Name:	
Last 4 digits of SSN:	**DOB:**
Relationship to Requestor/Applicant/Participant:	
Address:	
Home Phone #:	**Other Phone(s) #:**

(OPTIONAL)

2nd Responsible Representative Name:	
Last 4 digits of SSN:	**DOB:**
Relationship to Requestor/Applicant/Participant:	
Address:	
Home Phone #:	**Other Phone(s) #:**

REQUIRED:

Attestation for Responsible Representative(s): By signing below, I agree to be the designated responsible representative(s) for this participant. I understand that I may **NOT** be the participant's paid direct service worker. I also attest that I am not the representative for more than 2 individuals in any Medicaid Home and Community-Based Service.

Signature of Requestor/Applicant/Participant: _____ _____ (Date)

Signature of 1st Responsible Representative: _____ _____ (Date)

Signature of 2nd Responsible Representative: _____ (If Applicable) _____ (Date)

Signature of OAAS Designee: _____ _____ (Date)